

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-022508

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1618

FILED MAY 27 1963

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF	DOCUMENT
1 <u>4002</u>			
2 <u>4002</u>			
3			
4 <u>1</u>			
5 <u>2</u>			
6			
7 <u>1</u>			
8 <u>2</u>			
<u>9331X</u>			
10			
11			
12 <u>90-0</u>			
13			
ITEM NO.	SHOULD READ	BY AFFIDAVIT OF	

USE BLACK INK  
OR  
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clayton</u>		c. CITY OR TOWN <u>Clayton</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6342 Southwood</u>		d. STREET ADDRESS (If outside, give location) <u>6342 Southwood</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>H</u> Last <u>BROWN</u>		4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/9/1885</u> 9. AGE (last birthday) <u>77</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>Edgewood Illinois</u> 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>Elmer Hoffman</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Helen Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u> 17. INFORMANT Address <u>Mrs. James Thompson 63 Aberdeen Pl.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Haemorrhage with Paralysis Left.</u> DUE TO (b) <u>Arteriosclerosis with Hyper Tension.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
20f. CITY, TOWN, OR LOCATION _____		COUNTY _____ STATE _____	
21. I attended the deceased from <u>3/18/47</u> to <u>5/17/63</u> and last saw her alive on <u>5/16/63</u> Death occurred at <u>8:15 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>634 North Grand Ave.</u>	
22c. DATE SIGNED <u>5/17/63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>5/20/1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Edgewood Ill.</u>		23d. LOCATION (City, town, or county) (State) <u>Edgewood Ill.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Lupton Chapel 7233 Delmar Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>5-19-63</u> 26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

(Licensed Embalmer's Statement on Reverse Side)

Dr. W. P. Wade  
No THEAT Bldg

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Clarence H. Murray*

Licensed Embalmer No. 4011

P. O. Address

*H. Lewis Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.